KAMALA D. HARRIS
Attorney General of California
DIANN SOKOLOFF
Supervising Deputy Attorney General
CAROL ROMEO
Deputy Attorney General
State Bar No. 124910
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2141
Facsimile: (510) 622-2270
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **VEDA MAUREEN GLAZIER** **A.K.A. VEDA MAUREEN GADWOOD** **14213 Wycliff Way** **Magalia, CA 95954** **Registered Nurse License No. RN 258427** Respondent.	Case No. 2011-1001 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1975, the Board of Registered Nursing issued Registered Nurse License Number RN 258427 to Veda Maureen Glazier, also known as Veda Maureen Gadwood (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in this Accusation and will expire on June 30, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

6. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, gross negligence in carrying out usual certified or licensed nursing function."

8. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Section 11173(a) of the Health and Safety Code states that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge, or (2) by the concealment of a material fact.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. "Vicodin" and "Vicodin ES" are Schedule III controlled substances pursuant to Health and Safety Code section 11056(e)(4), and dangerous drugs within the meaning of Business and Professions Code section 4022. Vicodin is a trade name for the narcotic substance dihydrocodeinone with the non-narcotic substance acetaminophen. Each tablet of Vicodin contains 5 mg. of hydrocodone bitartrate and 500 mg. of acetaminophen.

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FIRST CAUSE FOR DISCIPLINARY ACTION

(Falsify, Make Grossly Incorrect, Inconsistent, or Unintelligible Entries In Patient/Hospital Records Pertaining to Controlled Substances or Dangerous Drugs)
(Bus. & Prof. Code §2762(e))

12. Respondent has subjected her Registered Nurse License to disciplinary action under section 2762, subdivision (e), of the Code on the grounds of unprofessional conduct in that Respondent made grossly incorrect, or grossly inconsistent entries in hospital or patient records pertaining to controlled substances and/or dangerous drugs. Specifically, while employed as a registered nurse in the recovery room at Advanced Surgery Center in San Jose, California, from on or about July 9, 2009, to on or about July 21, 2009, Respondent engaged in the following conduct:

a. **Patient-1[1]:**

On July 9, 2009, the physician for Patient 1 issued an Anesthesia Assessment and Order,[2] which included post-operative orders of Demerol 10 mg. IV x 2 as needed for pain and Zofran 4 mg. IV as needed for pain. Patient-1's physician did not order Vicodin. On July 9, 2009, at 10:00 a.m., Respondent documented on the Controlled Substances Log,[3] that she obtained two Vicodin 5/500 tablets for Patient-1.

Respondent obtained two Vicodin 5/500 tablets for Patient-1 without the physician's order. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effects of the medication. Respondent failed to chart wastage or otherwise account for the medication.

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[1]. All patients are identified by Numbers in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

[2] An Anesthesia Assessment and Order is used by the Physician to document controlled substances under the sections titled pre-operative orders and post-operative orders.

[3] Controlled Substances are documented on the Controlled Substances Log. The column showing the drug and dosage is to be totaled and reconciled for each drug removed from the narcotic cabinet. Documentation on the Controlled Substances Log is to include the date and time a drug is removed, the last name of the patient, the first and last name of the patient if there is more than one patient with the same last name, and the quantity of medication removed from the narcotic cabinet.

b. **Patient-2:**

On July 9, 2009, (time not charted), Respondent documented on the physician's Anesthesia Assessment and Order two Vicodin 5/500 tablets as needed for pain for Patient-2. On July 9, 2009, at 10:45 a.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-2. On July 9, 2009, at 2:10 p.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-2. The information contained on the Post-Operative Assessment[4] shows that Patient-2's allergies include Vicodin.

Respondent obtained a total of four Vicodin 5/500 tablets under Patient-2's name, which was in contradiction to information contained on the Post-Operative Assessment, which shows that Patient-2's allergies include Vicodin. Respondent failed to chart the administration of four Vicodin 5/500 tablets, and the effects of the medication. Respondent failed to chart wastage or otherwise account for the medication.

c. **Patient-3:**

On July 10, 2009, physician orders, as documented by Respondent, do not show a physician's order for Vicodin for Patient-3. On July 10, 2009, at 12:00 p.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-3.

On July 10, 2009, Respondent obtained, without the physician's order, two Vicodin 5/500 tablets under Patient-3's name. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effects of the medication. Respondent failed to chart wastage or otherwise account for the medication.

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[4] Post-Operative Assessment Report (PACU) includes the medication administration record. PACU/Recovery Room nurses are required to document medication administration and pain levels on this report.

d. **Patient-4:**

On July 10, 2009, physician Anesthesia Assessment and Order, as documented by an illegible RN name, shows an order for "1 moderate 2 for severe" oral analgesic as needed for pain. The drug to be administered was not charted. On July 10, 2009, Patient-4 was discharged from Advanced Surgery Center. On July 11, 2009, Respondent documented on the Controlled Substances Log that she removed two Vicodin 5/500 tablets for Patient-4.

On July 11, 2009, Respondent obtained, without a physician's order, two Vicodin 5/500 tablets under Patient-4's name. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effects of the medication. Respondent failed to chart wastage or otherwise account for the medication. Patient-4 was not a patient at the Advanced Surgery Center on July 11, 2009.

e. **Patient-5:**

On July 11, 2009, the physician's Anesthesia Assessment and Order for Patient-5 as documented by Respondent shows one Vicodin 5/500 tablet as needed for pain before discharge. On July 11, 2009, at 9:20 a.m., Patient-5 was discharged from the Advanced Surgery Center. On July 11, 2009, at 9:45 a.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-5. On July 11, 2009, at 0950 hours, Respondent documented on the Post-Operative Assessment that she administered Vicodin to Patient-5 and that the patient's pain level was "3." Respondent documented that the patient was discharged at 9:20 a.m. on July 11, 2009.

On July 11, 2009, at 9:45 a.m., Respondent obtained Vicodin under Patient-5's name after Patient-5 was discharged from the Advanced Surgery Center at 9:20 a.m. Respondent failed to follow the physician's order to administer only one Vicodin 5/500 tablet. Respondent's documentation for the pain levels is inconsistent and unclear in that it does not spell out what "3" represents with respect to pre and post pain medication levels.

f. **Patient-6 and Patient-7:**

On July 13, 2009, Patient-6 (eight years old) and Patient-7 (seventy-three years old) both with the same last name were admitted to the Advanced Surgery Center. Neither patient

had a physician's order for Vicodin. On July 13, 2009, at 10:00 a.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for one patient with the same last name as Patient-6 and Patient-7. The post-operative assessment record for Patient-6 was not completed by Respondent and does not show that Vicodin was administered to Patient-6. The post-operative assessment record for Patient-7 was completed by Respondent and shows that Respondent documented the patient's pain level to be "0."

On July 13, 2009, at 1000 hours, Respondent obtained, without a physician's order, two Vicodin 5/500 tablets under Patient-6's or Patient-7's names. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effects of the medication. Respondent failed to chart wastage or otherwise account for the medication.

g. **Patient-8:**

On July 16, 2009, the physician's Anesthesia Assessment and Order for Patient-8 shows one Vicodin 5/500 tablet as needed for pain. On July 16, 2009, at 2:20 p.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-8. On July 16, 2009, at 2:20 p.m. Respondent documented on the post-operative assessment the administration of two Vicodin 5/500 tablets for Patient-8. Respondent documented on the post-operative assessment that Patient-8's pain level was "3/10."

On July 16, 2009, Respondent failed to follow the physician's order to administer only one Vicodin 5/500 tablet to Patient-8 as needed for pain.

h. **Patient-9:**

The July 17, 2009 physician's Anesthesia Assessment and Order does not show an order for Vicodin 5/500 and/or any other oral analgesics for Patient-9. On July 17, 2009, at 1045 hours, Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-9. Respondent documented on the post-operative assessment that the patient's pain level was zero.

On July 17, 2009, Respondent obtained, without a physician's order, two Vicodin 5/500 tablets under Patient-9's name. Respondent failed to chart the administration of two

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Vicodin 5/500 tablets, and the effect of the medication. Respondent failed to chart wastage or otherwise account for the medication.

i. **Patient-10:**

The July 20, 2009 physician's order does not show an order for Vicodin for Patient-10. On July 20, 2009, at 11:30 a.m., Patient-10 was discharged from the Advanced Surgery Center. On July 20, 2009, at 2:10 p.m., Respondent documented on the Controlled Substance Log that she removed two Vicodin 5/500 tablets for Patient-10. Respondent documented on the post-operative assessment at 11:10 a.m. that Patient-10's pain level was "0."

On July 20, 2009, at 2:10 p.m., Respondent obtained two Vicodin tablets under Patient-10's name without a physician's order and after Patient-10 was discharged from the Advanced Surgery Center on July 20, 2009 at 11:30 a.m. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effect of the medication. Respondent failed to chart wastage or otherwise account for the medication.

j. **Patient-11:**

The July 21, 2009 physician's order shows "2 Vicodin for back pain VO" (verbal order) as documented by Respondent on July 21, 2009 at 9:15 a.m. On July 21, 2009, at 9:15 a.m., Respondent documented on the Controlled Substance Log a "late entry" for her removal of two Vicodin 5/500 tablets for Patient-11. Respondent documented the administration of two Vicodin 5/500 tablets to Patient-11 on the post-operative assessment and nursing notes. The pain level is documented as "3."

Patient-11's physician did not give a verbal order and/or any other order for Vicodin to be administered to Patient-11. Respondent's documentation for pain levels is illegible and inconsistent in that it is unclear what the "3" represents with respect to pre and post pain medication levels.

Respondent obtained two Vicodin 5/500 tablets under Patient-11's name without a physician's order. Respondent failed to chart the administration of two Vicodin 5/500 tablets, and the effect of the medication. Respondent failed to chart wastage or otherwise account for the medication.

SECOND CAUSE FOR DISCIPLINARY ACTION
(Obtained, Possessed and Self –Administered Controlled Substance)
(Bus. & Prof. Code §2762(a))

13. Respondent has subjected her Registered Nurse License to disciplinary action under section 2761, subdivision (a), of the Code on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a). Specifically, as set forth above in Paragraph 13, Respondent committed the following acts:

a. She obtained Vicodin, a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173.

b. She possessed Vicodin, a controlled substance, in violation of Business and Professions Code section 4060.

THIRD CAUSE FOR DISCIPLINARYACTION
(Unprofessional Conduct - Gross Negligence)
(Bus. & Prof. Code §2761(a))

14. Respondent has subjected her Registered Nurse License to disciplinary action under section 2761, subdivision (a)(1), of the Code on the grounds of gross negligence based on the acts and/or omissions set forth in paragraph 13, above.

FOURTH CAUSE FOR DISCIPLINARYACTION
(Unprofessional Conduct - Incompetence)
(Bus. & Prof. Code §2761(a))

15. Respondent has subjected her Registered Nurse License to disciplinary action under section 2761, subdivision (a)(1), of the Code on the grounds of incompetence based on the acts and/or omissions set forth in paragraph 13, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 258427, issued to Veda Maureen Glazier, also known as Veda Maureen Gadwood (Respondent);

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2. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: June 21, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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CR: 06/14/11